AN OVERVIEW OF THE WISCONSIN HEALTH CARE LIABILITY AND PATIENTS COMPENSATION ACT

A REPORT TO THE SJR 32 SUBCOMMITTEE ON MEDICAL LIABILITY INSURANCE

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Introduction

On January 15, 2004, the SJR 32 Subcommittee on Medical Liability Insurance asked its staff to prepare and present an overview of the Wisconsin Health Care Liability and Patients Compensation Act (HCLPCA or Act), enacted in 1975. The narrative that follows describes the primary components of the Act in a question-and-answer format. The statutory language of the Act is codified at Chapter 655, Wisconsin Statutes, and is available on line at http://folio.legis.state.wi.us/, then follow the links.

What is the Wisconsin HCLPCA?

The Act is composed of two primary parts. One part establishes a liability environment for "health care" that is materially and procedurally different from the general liability environment. The other part establishes an environment for compensating patients who are injured as a result of malpractice that is materially different from the general liability environment.

The second part, the liability program established by the Act, is a mandatory excess insurance program that supplements but does not replace the existing, private, medical malpractice insurance marketplace. The program provides higher limits of liability insurance to health care providers and facilities than might otherwise be available or affordable. The liability program also requires and restricts certain actions by the parties affected by medical liability claims. In common parlance, these actions are referred to as "tort reforms".

The compensation program, manifested in the Patients Compensation Fund (PCF) and the processes associated with it, adds "capacity" to the liability insurance market and enables existing medical malpractice carriers to sell more policies. The logic underlying the program is: If the existing carriers do not have to allocate capital to sell higher limits of coverage, they can allocate that capital to sell more policies.

As briefly as is practical, the Act:

- establishes liability insurance requirements and restrictions on medical providers, medical facilities, and medical liability insurers;
- establishes requirements and restrictions on malpractice claimants, including their representatives and heirs;
- limits the remedy for malpractice exclusively to the provisions of the Act;
- establishes processes for making and resolving malpractice claims;
- establishes limits on attorney fees payable for malpractice claims;
- establishes procedures for the management, by a public entity, of compensation paid to a claimant for medical costs that result from malpractice by a medical provider or facility;
- imposes limits on noneconomic damages payable for malpractice;
- establishes procedures for setting fees to sustain and operate the patients compensation programs;
- disallows a medical practitioner or facility from rejecting a settlement agreed to by an insurer and claimant;
- precludes an insurer from cancelling or not renewing a liability policy, except in certain circumstances;
- requires medical liability insurers to file monthly reports on the details of each claim paid during the previous month;
- creates a "patients compensation fund" designed to compensate, in certain cases, certain claimants who have suffered from malpractice and to protect medical providers, facilities, and insurers from unusually large claims payments;
- establishes and provides for the administration of the Act, particularly the PCF;
- establishes processes for post-claim award review and mediation;
- requires various reports from various entities at various times for various purposes;
- establishes and provides for the administration of a "mediation fund", which essentially is an appendage of the Act.

Who is affected by the provisions of the Act?

There are basically two categories of persons who are affected by the provisions of the Act. The first category includes all (except as described below) of the following in Wisconsin: physicians, nurse anesthetists, any partnership composed of physicians or nurse anesthetists, or both; any corporation organized and operated in Wisconsin for the primary purpose of providing the medical services of

physicians or nurse anesthetists, or both; any cooperative sickness care association that operates a nonprofit sickness care plan in Wisconsin and that directly provides services through salaried employees in its own facility; any ambulatory surgery center that operates in Wisconsin; any hospital that operates in Wisconsin; any entity operated in Wisconsin that is an affiliate of a hospital and that provides diagnosis or treatment of or care for patients of the hospital; and any nursing home whose operations are combined as a single entity with a hospital, whether or not the nursing home operations are physically separate from the hospital operations. (However, this category does not include: a physician or a nurse anesthetist who is a state, county, or municipal employee, or a federal employee or contractor covered under the federal tort claims act and who is acting within the scope of his or her employment or contractual duties.) Participation by active Wisconsin providers is mandatory. There are some providers for whom coverage is optional, e.g., Michigan physicians doing substantial business in Wisconsin.

The second category is composed of: any person/patient (or representative of a person/patient) who received or should have received health care services from a health care provider or from an employee of a health care provider acting within the scope of his or her employment if the person makes a claim; or any spouse, parent, minor sibling or child of the person/patient, which spouse, parent, minor sibling or child of the person/patient has a derivative claim for injury or death on account of malpractice. All claims made are subject to the provisions of the Act.

Why was the program created?

The program was created in 1975 as a response to the first medical malpractice insurance crisis. Events at that time disrupted the lives of physicians and the people they serve in ways similar to disruptions reportedly occurring nowadays in various jurisdictions.

Market disruptions that were occurring in the 1970s were likely due, in part, to economic conditions and to the tort system. Medical providers and facilities in Wisconsin and many other states had experienced a "hard" liability insurance market – providers and facilities could not afford or in some cases even buy the

insurance they needed.

The market disruption was partially a result of the economic law of supply and demand. The insurance industry did not have the capacity to supply enough insurance at affordable prices to meet the needs of health care providers. The program was established to immediately expand access to insurance and to provide, in the longer term, a reliable source of insurance capacity.

How did the program create additional malpractice insurance capacity?

The program, through the PCF, is an excess insurance or reinsurance program. The PCF pays for claims that exceed a certain dollar threshold. By launching an insurance program to cover the high end of a claim, the state infused new capacity into the system. The program relieved the existing market of the pressure to reserve for the most expensive claims and, thus, additional capacity was created immediately in the existing market. Since inception in 1975, the PCF has continued to provide liability insurance capacity above what there would be absent the program.

What level of insurance coverage does the program provide?

Under Wisconsin law (April 2003), health care providers must obtain primary medical malpractice insurance from private insurance companies in the amount of $1 million per occurrence and $3 million per policy year in the aggregate. (A self-insured provider must have a minimum of $800,000 of primary coverage.) The PCF provides coverage in excess of the primary insurance, and PCF coverage is unlimited.

How does this program stabilize the medical malpractice marketplace?

The Wisconsin program initially provided an immediate increase in capacity and continues to provide some added level of capacity with respect to higher limits of coverage. The private market in Wisconsin is no longer wholly dependant on the ability of domestic and international reinsurers to provide excess coverage.

In the past, capacity for excess insurance was driven by economic conditions beyond Wisconsin's borders that cause fluctuations in the worldwide insurance marketplace. At times, reinsurers essentially dictated whom primary insurers can cover, the prices primary insurers charge, and the coverage primary insurers provide. The PCF allows medical liability insurers and the insured in Wisconsin to affect, at some level, pricing and coverage decisions.

Importantly, the primary effect (and goal?) of the program has been to increase the availability of liability insurance. The price of liability insurance, especially for primary coverage, is still market driven.

How is the Wisconsin PCF capitalized?

Initially, the PCF was not capitalized. Rather, it operated on a cash basis during its first 5 years of existence. (The State of Montana's self-insured general liability insurance program currently operates on a cash basis.) During the 1980's, the PCF switched from cash accounting to accrual accounting to improve the integrity of the fund. Under the accrual method, providers are assessed an amount that is based on estimates of what all claims would total over time for incidents that occurred in any given year, rather than on what the payout amount was for that year. Accrual accounting ensures that the PCF has sufficient assets to pay all outstanding liabilities, including claims incurred but not reported, if the PCF were discontinued. The estimates of what claims would total over time are actuarially determined. Wisconsin requires insurers to be financially solvent such that their assets are sufficient to cover any outstanding liabilities. Therefore, if an insurer stops doing business, all outstanding claims against the insurer will be paid. The PCF is currently operated in a similar manner.

Does the Wisconsin program affect the price of malpractice insurance?

In total, the programs may affect liability insurance premiums but, ultimately, any effect on pricing may be unknowable. At best and to the extent that pricing is affected, which aspect(s) of the entire program accounts for which portion of any pricing effect is elusive.

The programs created by the Act are multi-faceted and include components about which some advocates and some opponents fundamentally disagree. For example, the Wisconsin program includes many elements that tort reform advocates hail as economically vital and that consumer advocates assail as false prescriptions or red herrings. The programs' other elements -- (medical) jurisprudence reforms, medical practice reforms, insurance reforms -- also have their own advocates and detractors.

Is the program simply a bonus for special interests?

Medical providers and facilities and medical liability insurers are the most obvious and directly affected beneficiaries. To the extent that any of those groups is a "special interest", the program may be a bonus. However, to the extent that liability insurance and tort law affect access to and the cost of medical care, there are numerous others who benefit indirectly, with the potential that everyone who receives or merely has access to medical care in Wisconsin receives some residual bonus. Consequently, distinguishing the special interests from within the general interest is both personal and difficult.

On the flip side of the special interest coin, persons injured through medical negligence may be denied something perceived to be "full compensation" for the negligent acts of medical providers or facilities. Reinsurers may miss out on lucrative business. Attorneys may forego income due to caps on contingency fees. Medical providers and facilities forego their freedom of choice regarding excess liability coverage, both from whom it is purchased and at what level of coverage. The insured, the insurers, and injured persons are all compelled to follow laws and procedures that they may not particularly like or believe in, and so on.

How financially healthy or stable is the PCF?

According to a report from the Wisconsin Legislative Fiscal Bureau staff[1], the PCF

[1] *Patients Compensation Fund*, Paper #458, by Kim Swissdorf, Wisconsin Legislative Fiscal Bureau, April 23, 2003.

had approximately $588 million in assets and about $582 million in estimated liabilities at the end of fiscal year 2002. The report also stated that the amounts contemplated to be payable for current-but-unsettled claims and future claims had historically exceeded actual claims by a significant amount. That fact has also caused the Board of Governors of the PCF to regularly set annual assessments for providers and facilities at levels considerably less that the amounts recommended by the actuary. In the most recent year reported, the actuary had recommended an increase of 117.4%, but the Board set the increase at only 5%.[2] (Of the nine fiscal years from 1994-95 through 2002-03, the Board commonly set assessments 10 percentage points or more *below* the levels advised by the actuary.) Considering the PCF has a positive equity of ~$6 million, particularly, given previous Boards' actions in setting assessments, it appears that the PCF is relatively stable.

Are the citizens of Wisconsin on the hook to pay claims?

As the program is designed, Wisconsinites are not on the hook to pay claims. The legal framework of the program has created, ostensibly, a quasi-private insurance entity that is removed from direct agency with the State of Wisconsin. The entity does not act as an agent of the state (as would a Department of Health employee, an elected official, or a contractor in their official capacity) and, theoretically, should not legally be treated as an agent of the state.

However, the State of Wisconsin, through the Board of Governors and the Insurance Commissioner each acting in their statutory capacity, is a party to the programs. Because the programs are a creation of the state, there may be at least a moral obligation for the state, i.e., taxpayers, to pay for outstanding liabilities if the PCF is ever unable to pay.

Is the Wisconsin approach unique?

In many way, no; in some ways, yes. According to the Wisconsin Legislative Fiscal

[2] Ibid., p. 5.

Bureau, there are eight states, plus Wisconsin, that have some type of a PCF.[3] Of the nine "PCF states", participation by providers and facilities is mandatory in Kansas, Pennsylvania, and Wisconsin. Coverage is unlimited in South Carolina and Wisconsin. Wisconsin's primary coverage requirements of $1 million per incident and $3 million per policy year are higher than any of the other PCF states. Finally, Wisconsin is the only state that has both a mandatory participation requirement *and* unlimited coverage.

What options have other states pursued?

The options available to all states include the ways in which:

- liability coverage is provided;
- compensation is meted out.

The "liability coverage" options include: whether the state's program is optional or mandatory; the coverage limits, e.g., $1 million/$3 million; and the allocation of the costs of the program, i.e., participants are assessed proportionately, uniformly, or by some other measure.

The potential *processes* to determine the amount of PCF compensation provided by programs include: "no fault" compensation (akin to workers' compensation); voluntary arbitration; mandatory arbitration; medical malpractice courts; various mechanisms for appeals; and others.

The options for determining the *amount* of compensation include: PCF coverage for a fixed-dollar maximum amount, e.g., the amount of the claim above the insured's private-policy maximum up to a maximum amount, e.g., $1 million; PCF coverage for a fixed-percentage maximum amount, e.g. 50% of the amount of the claim above the insured's policy maximum up to a maximum amount, e.g., $1 million; for unlimited PCF coverage above the insured's private-policy maximum; combinations of the above.

[3] Ibid, p. 4.

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